STERILIZATION/DECONTAMINATION REQUEST

CLINIC/WARD: _____ **PHONE NO.:** _____ **DATE:** _____

INSTRUMENT	QTY RCVD	QTY RTND

SPECIAL INSTRUCTIONS: _____

_____

_____

_____

RECEIVED

CMS SIGNATURE: _____

CLINIC/WARD: _____

RETURNED

DATE: _____ **TIME:** _____

CMS SIGNATURE: _____

CLINIC/WARD: _____

MEDDAC (Ft Meade) Form 630, 1 Aug 96

Version of 1 Oct 95 is obsolete and will not be used.